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November 2, 2007

To: Zev Yaroslavsky, Chairman
Supervisor Gloria Molina
Supervisor Yvonne B. Burke
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer

BOARD MOTION TO DEVELOP SUPPORTIVE HOUSING TO SERVE THE CHRONICALLY HOMELESS – STATUS UPDATE

This is to provide your Board with a status update and request a 30-day extension, in response to the July 24, 2007, motion by Chairman Yaroslavsky and Supervisor Burke. The motion instructed our office to develop protocols that facilitate consistent partnerships with cities and other entities interested in delivering housing linked to supportive services that reduce homelessness throughout the County. Specifically, your Board directed the following: (1) Develop an inventory of Countywide supportive services; (2) Create a process that will facilitate contingent commitments of supportive services for developers of supportive housing; (3) Develop a process for ensuring that inclusion of well defined performance based outcomes for all homeless funded projects; (4) Prepare a report to the Board that identifies best practice supportive housing models in California; (5) Develop a mobile supportive services program model and budget; and (6) Develop proposals for State and Federal legislative and regulatory policy change and report back within 90 days.

My office has convened the County's Homeless Coordination Team (Homeless Team) to develop specific strategies in response to your Board's request. The Homeless Team is tasked with addressing ongoing challenges related to homelessness and to create strategies that will adequately provide solutions to those challenges. The County departments/agencies that participate on the Homeless Team are: Public Social Services (DPSS), Mental Health (DMH), Public Health (DPH), Health Services (DHS), Children and Family Services (DCFS), Probation, Sheriff, Community Development Commission (CDC), and Public Defender (PD). The Los Angeles Housing Services Authority (LAHSA) is a non-County participant. The Team is chaired by the Chief Executive Office's (CEO) Homeless Coordinator.

The following provides you with a brief update of the progress to-date on each direction included in the Board's July 27 motion:

- **Develop an inventory of Countywide supportive services that serve homeless families and individuals and those at-risk for homelessness for use by housing developers and other providers interested in developing supportive housing**: Under the leadership of the CEO's Service Integration Branch (SIB) and DPSS, a preliminary description of the purpose and potential uses for this inventory has been created. The group will refine this document within the next two weeks and move forward during the month of November 2007 to gather the necessary information from each County department to populate the inventory. It is expected that a final document will be ready for review by your Board in late November 2007.

- **Create a process that will facilitate contingent commitments of supportive services between the County, cities, and developers of supportive housing projects.** The intent of early commitments by the County will allow developers to leverage adequate public and private funds needed to complete these projects. At the beginning of 2006, members of the Special Needs Housing Alliance (SNHA), in partnership with the City of Los Angeles, agreed to review the supportive services portion of the Request for Proposals (RFP) submitted to the City of Los Angeles to develop and/or fund permanent supportive housing throughout the City. Subsequent to this County review of the City's proposals, the City and County staff met to discuss ways in which to improve coordination and collaboration as the City moves forward with additional permanent supportive housing funding RFPs. As a result of this meeting, a number of steps have been taken to enhance collaboration including County participation in RFP development and pre-proposal conferences. These existing collaborative efforts along with a process by which the County may provide contingent supportive service commitments will ensure that County-City efforts align and complement each other, as well as better leverage limited resources to meet the needs of the homeless population. In consultation with the City of Los Angeles and other cities within the County, the SNHA will develop over the next three months contingent commitment protocols.

- **Develop a process for ensuring the inclusion of well defined performance based outcomes** in all projects that the County supports through any funding source. All homeless related projects funded by the County are required to develop performance based outcomes as part of the contracting process that are in line with the County's *Performance Counts!* framework. SIB, in conjunction with the CDC, will work closely with funded contractors to further refine and monitor outcomes for all projects.

- **Prepare a report to the Board that identifies best practice permanent supportive housing models** in California and other parts of the nation that may be useful in the County for serving chronically homeless individuals, families, and transition age youth. SIB has created a Best Practices overview that details local and national models that effectively address homelessness and that may be replicable in Los Angeles County (attached).

- **Develop a mobile supportive services program model and budget** that can provide County funded support services to permanent supportive housing projects in targeted geographic areas. Homeless Coordinators from DPH and DHS submitted a proposal to develop a mobile supportive services team to support homeless clients in community based programs. A workgroup has been formed to further develop the project to include a detailed budget. In addition, the workgroup will work to identify appropriate funding streams to support the implementation of the program.

- **Develop proposals for State and Federal legislative and regulatory policy change** that enable the creation of adequate funding streams for permanent supportive housing. The Office of Legislation and Intergovernmental Affairs and SIB are participating on an ongoing subcommittee which was created to identify possible regulatory and legislative reform that can be supported by your Board to increase flexible funding options at the State, local, and national levels. It is expected that regulatory changes in such public benefits as Medi-Cal and SSI can be made to allow the County to maximize its possible revenue sources in addressing the needs of the homeless population and the providers that serve them. We will continue to refine the legislative policies to assist in this effort.

In order to adequately address the various components of the Motion additional time is needed. We will provide your Board with the requested report no later than November 30, 2007.

If you have any questions or need additional information, please contact Deputy Chief Executive Officer Lari Sheehan at (213) 893-2477 or, via e-mail at lsheehan@ceo.lacounty.gov; or your staff may contact CEO Homeless Coordinator Garrison Smith at (213) 974-467 or, via e-mail at gsmith@ceo.lacounty.gov.

WTF:LS
KH:GLS:os

Attachment

c: Sheriff
Community Development Commission
Department of Public Social Services
Department of Children and Family Services
Department of Health Services
Department of Public Health
Department of Mental Health
Probation
Public Defender
Los Angeles Homeless Services Authority

BEST PRACTICES IN HOUSING PROGRAMS FOR THE HOMELESS

I. Homeless/Housing Programs across the Country

Government Entity	Program Description	Best Practices
Broward County, Florida[1]	Located on the southeastern coast of Florida, Broward County's primary industry is tourism, universally drawing people to its shoreline. Recognizing both the social and economic costs of homelessness, a group of individuals convened at the Florida Summit on Homelessness in 2004 to create a 10-year plan to end homelessness. The plan shifts their focus from emergency housing to permanent housing through the creation of more units for a stable and permanent living situation.	The most recent point-in-time count of homeless people in the county numbered 3,100 men, women, and children. Broward County is focusing on the rapid creation of at least 1,200 permanent housing units for homeless and at-risk individuals, mandatory inclusionary zoning in the county, and the use of public land for development by nonprofits. Broward County's plan also calls for systems prevention through expanded discharge protocol and the removal of the barriers to obtaining mainstream resources faced by homeless people. A housing specialist position will be created to address the barriers to housing and aid in the rapid rehousing of homeless individuals. Full implementation of the HMIS as well as the ability to interface with other service delivery databases will improve the quality of data and ability to identify trends for preventive intervention. Finally, the plan calls for the expansion of the Living Wage Ordinance passed in 2002 to address the gap between income and affordable housing. Further, improving education and equipping homeless and at-risk populations with job readiness and training is imperative to the maintenance of long-term housing. Included in their strategy, Broward County encourages improved communications between Homeless Service Providers and Employment Services to offset the increasingly difficult task of finding and keeping housing because of the rising costs in the county. Leveraging the $9 million they received from federal contributions, Broward County government invested $12 million in 2005 for homeless services, and raised $8 million from private donors for homeless services. Currently, the steering committee is soliciting increased support, and working on expanding its membership to include members of the local business community, corrections, and hospital districts as well as homeless and formerly homeless individuals. This expanded group will formulate the "Implementation Committee," which will be used to identify new resources, assess existing resources, and establish annual targets for success. Source: *A Way Home: Broward County, Florida's Ten Year Plan to End Homelessness*
Chattanooga, Tennessee[1]	Chattanooga's plan, titled *The Blueprint to End Chronic Homelessness in the Chattanooga Region in Ten Years,* relies on four primary "spheres of activity." Each sphere includes realistic strategies to address and end homelessness in the Chattanooga region.	*1. Expand permanent housing opportunities* – Chattanooga's plan calls for creating 1,400 new affordable housing units over the next 10 years through the provision of rent subsidies, new housing development, and the preservation of the current affordable housing stock. Also, it will streamline housing placement services through a centralized housing assistance office that will locate units and identify prospective clients. In addition, the plan calls for the exploration of ways to prioritize homeless people for placement into subsidized housing. *2. Increase access to services and supports* – The plans reconfigures the current case management system to be more assertive, coordinated, and focused on placing homeless people in permanent supportive housing and keeping them there. Integral to increasing services and supports available is the prioritization of funding for supportive services to both homeless and formerly homeless people in permanent supportive housing. Linking homeless and formerly homeless individuals to mainstream services as well as improving the effectiveness of outreach and engagement of unsheltered homeless persons are necessary ingredients in Chattanooga's plan. *3. Prevent homelessness* – The plan calls for establishing a system that identifies people at risk of homelessness and aids them in stabilizing their housing by providing emergency assistance, improving access to supportive services, and maximizing their income. It also calls for developing permanent housing plans prior to the release of individuals from prison, hospitals, shelter, treatment, and foster care, and establishing clear responsibilities for their implementation in each community.

Government Entity	Program Description	Best Practices
		4. Develop a mechanism for planning and coordination – A newly formed Chattanooga Regional Interagency Council on Homelessness will be responsible for enhancing the government and nonprofit's capacity to raise funds directed at ending homelessness, expanding the capacity for data collection and analysis, and determining funding priorities for homelessness reduction efforts. Establishing and maintaining standards of service delivery and case management and increasing and improving the collaboration efforts between for-profit, government, nonprofit, and faith-based initiatives will also be within the jurisdiction of the Council. Source: *The Blueprint to End Chronic Homelessness in the Chattanooga Region in Ten Years*
Chicago, Illinois ARCH (ACT Resources for the Chronically Homeless) [2]	In 2003, the Chicago Continuum of Care responded to the federal NOFA for the Collaborative Initiative to Help End Chronic Homelessness. This NOFA, for the first time, combined funding from HHS, HUD, and the VA to create housing resources for single individuals who meet the federal definition of chronic homelessness. Chicago's successful application resulted in $3.4 million dollars in federal money to create a harm reduction model of permanent supportive housing for 59 long-term homeless individuals in the city over a five-year period (2004-2009). This project is called *ARCH (ACT Resources for the Chronically Homeless)*. The Chicago Continuum of Care's approach to this application was to have an inclusive and transparent process, a collaboration of nonprofit and government entities, a structure that emulates the Continuum structure, and one that addressed existing inequities in resource allocation. ARCH focuses on the long-term homeless population on the south side of Chicago. Each partner applied for a portion of the $3.4 million needed for the project to succeed. Taken together, this funding provides housing subsidies, supportive services, primary health and dental care and Veteran's services.	Accomplishments • Interagency collaboration has established a new culture of cooperation, increased resources for tenants, and created a structure where partners support the project by filling in where needed. • Interagency collaboration ensures that the program benefits from a variety of perspectives and organizational cultures so that no one agency or service system dominates the services and culture of the ACT team. • The wide spectrum of providers involved (substance abuse, mental health, housing) ensures that tenant needs are met, no matter what type of assistance or treatment they may need and that there is no wrong door for entry. Lessons Learned • Consider creating MOUs with all team partner agencies before submitting an application. If this is not possible, at least outline very clearly the commitment and responsibility of all partner agencies. During the NOFA phase, organizations were eager to participate on the ACT team, but once the grant was funded, the details of their participation became more complicated. • When working with many different agencies, differences in institutional cultures, policies, and procedures must be addressed. Creating the ARCH entity was complex; the ACT Team is comprised of staff from eight different organizations. Each organization has its own culture and policies and procedures. Subcontracts with consistent salaries and policies for all members of the team had to be negotiated with each organization. This was complicated and time-consuming and delayed the initial start-up. • It is easier to integrate existing staff into a new project than to hire new staff just for the project. The staff hired for the ACT team required more training than originally anticipated and this also led to a delay in the initial start-up. • The collaborative structure is beneficial, but a balance must be found between ensuring wide representation and having so many partners that managing the partnerships creates more work than the project itself. In future applications, they would reduce the number of organizations that have staff on the ACT Team. They chose to include eight organizations in their initial application because they were seeking to create an open and inclusive process at a time when many organizations were anxious about funding. In retrospect, the project would have been implemented more smoothly and quickly if we had reduced the number. • While initially harder during the start-up phase, the Collaborative model of ARCH, because it includes both nonprofit and government agencies, has the capacity to lead to more significant system change.
Chicago, Illinois	Created under the McKinney-Vento Act, Safe Havens offer a "housing first"	*Thresholds* provides on-site services 24 hours a day to help participants transition from "street or shelter" life to living inside in their own space. Service providers help participants make appointments, buy

Government Entity	Program Description	Best Practices
Safe Havens [2]	approach to help street homeless people with mental illness move into interim or permanent housing units. Thresholds in Chicago and Goddard Riverside Community Center's Project Reachout (PRO) in New York are two examples of Safe Haven programs aimed at ending chronic homelessness.	groceries, re-connect with family and complete myriad other life activities. The most important thing staff offer is a consistent relationship based on respect and concern. Staff takes extra effort to accept participants' pace and ability to connect to the community around him or her. Thresholds Safe Haven's menu of programming includes: "Community" meetings which focus on interpersonal relationships as well as information sharing, "House" meetings where people can share their past experiences and future housing goals, and community dinners to celebrate special events in participants' lives. Staff also lead "The Safe Group" which tours city sites and focuses on socialization and fun. Invaluable linkage resources such as the Northwestern Memorial Hospital's "Satellite Free Psychiatric Clinic" located in the Lawson YMCA, Westside Veterans Administration's Homeless Outreach Services and Thresholds Bridge North's ACCESS Teams have enabled many Safe Haven Participants to accept long-term case management and mental health services. These "partnerships" provide the type of continuum of care that sensibly responds to the individual needs of all Participants. Thresholds reports: "Of the 19 people we served last year, the average length of stay was 292 days with nearly 90% accessing mental health services and more than half obtained benefits." The lesson strongly taught by our participants has been, "Let me do it in my way and in my own time."
Connecticut [3]	Received the Innovations in American Government Award (Ash Institute for Democratic Governance and Innovation at Havard's JFK School of Government). A collaborative program with Connecticut Office of Policy and Management (OPM), in partnership with the Corporation for Supportive Housing (CSH), designed and launched the *Supportive Housing Pilots Initiative.* The Initiative's goal was to expand the availability of supportive housing across the state and increase the number of nonprofits engaged in the provision of supportive housing.	The strategy involved collaboration among OPM, the Department of Mental Health and Addiction Services, the Department of Social Services, the Department of Economic and Community Development, the Connecticut Housing Finance Authority (CHFA), and CSH. The state and the CHFA, with encouragement from advocates such as the Partnership for Strong Communities, committed $35 million in capital financing, which in turn leveraged another $30 million in private-sector investment. In addition, the state allocated $5 million in annual funding for supportive services for supportive housing projects developed through the Pilots Initiative, and $5 million dollars in HUD funding was used for operating support. According to the winning application, before implementing the new strategy, the state developed a model for creating supportive housing that included: • Engaging the philanthropic community in a leadership role Building consensus among key state agencies about the core principles of the housing and services to be funded • Establishing production goals and timelines • Developing a detailed strategy for implementing projects • Identifying funding for the capital, services, and operating needs of supportive housing providers • Encouraging participation in the development of supportive housing by providing flexible predevelopment financing, training, and technical assistance for nonprofit housing developers • Making a commitment to quality assurance The results have been impressive. More than 400 new households have been created in 25 Connecticut communities for formerly homeless adults and families, and another 300 are under development. A survey of 126 tenants who have remained in their homes for three years or more shows that their use of acute and expensive health services has been reduced by more than 70 percent because of their access to outpatient and preventive health care. According to the state, a study by the Department of Mental Health and Addiction Services found that individuals housed through the Pilots Initiative experienced "increased independence, better quality of life, reduced isolation, and greater housing stability." Perhaps most impressively, Connecticut has accomplished this at a cost of about $36 a day per unit, far below the daily cost for the crisis services often used by homeless persons. The program silos (e.g., housing, social services, health care) that often make it difficult to create policy

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		solutions to complex social problems historically have been an impediment to successfully addressing homelessness. In Connecticut, the Pilots Initiative confronted this problem at the outset through the development of a Memorandum of Understanding (MOU) among all five state partners. The MOU established each agency's role, responsibility, and commitment, and outlined the collaborative funding process. The state reports that the MOU and the experience of jointly implementing the Pilots Initiative helped each agency reach a common understanding of the problem to be solved, gain an increased familiarity with the language and cultures of other agencies, and make the necessary changes to old agency habits that once served as barriers to cooperation.
Contra Costa County, California[1]	For the past 20 years, Contra Costa County, California has been addressing homelessness through comprehensive, countywide initiatives involving 96 housing and service organizations in the area, including nationally recognized programs. In 2004, however, the county decided it was time to take a different approach. New cases of homelessness, chronically homeless people cycling through the system without attaining the help they need, and increasing amounts of people turned away from assistance because of lack of space indicated to Contra Costa that there were flaws in the current system. The Contra Costa County plan to end homelessness asserts that communities can eradicate homelessness if enough resources are invested wisely to address the problem successfully.	Contra Costa County's plan consists of five key priorities that, if implemented, would make possible the goal of ending homelessness in 10 years. First, adopting the Housing First approach will allow the county to help homeless persons in Contra Costa County access stable housing as quickly as possible, and then link them with the appropriate services and supports. The second priority is to provide wraparound services by integrating homeless and mainstream services at both the system and client level. This strategy also includes the systemwide data collection through the HMIS to better understand the needs of the homeless population in Contra Costa. Essential to housing stability is employment that provides a "housing wage," the wage level that allows people to pay no more than 30 percent of their income to rent. Enhancing the ability of homeless people to access and maintain housing wage employment in order to increase their level of self-sufficiency is the third priority. Enacting a "Hire Homeless First" policy for all local government, entry-level employment opportunities and a housing wage ordinance that links minimum wage to housing costs are two of the action steps Contra Costa County has included in their strategy. Contra Costa's plan includes an aggressive approach to incorporating the often mistrustful chronically homeless population. Developing teams comprised of specialists from a number of pertinent disciplines, outreach to the chronically homeless will be expanded and intensified. Low case loads will allow the outreach team to build trust and successfully link services with needs in this often difficult-to-serve homeless population. The final priority is the implementation of homeless prevention. The expansion of existing emergency prevention services, case management, and legal assistance, as well as the creation of housing support centers, will aid in the elimination of new cases of homelessness. The plan also calls for a new "bridge subsidy" program dedicated to those at risk of homelessness. Contra Costa County recognizes prevention as the most humane and cost-effective way to end homelessness, and thus all mainstream health and social service programs should join the effort to prevent homelessness in the county. Source: *Ending Homelessness in Ten Years: A County-Wide Plan for the Communities of Contra Costa County, 2004*
Denver, Colorado[1]	In June 2003, the city of Denver elected a new mayor and 10 new city council members. Recognizing the opportunity for change in the city's homelessness policy, a group of local and nonprofit stakeholders joined together in taking the necessary steps toward a 10-year plan to end homelessness. *The Ten Year Plan to End Homelessness,* a report to the citizens of Denver by the Denver Commission to End Homelessness, was formally introduced in May 2005. Extensive research of the	Eight Goals: 1. Increase permanent housing available to those at or below 30% AMI and to expand temporary housing to provide a safety net while new housing stock is put into place. Denver aims to produce 94 new housing units with supportive services per year, thus reducing chronic homelessness by 75% in the first five years. 2. Provide safe and legal shelter to those who have recently become homeless, targeting 135 new shelter beds in Year 1. 3. Address prevention through increased resources for support services such as credit counseling, rental fee waivers, and foreclosure prevention assistance. 4 & 6. Target specific needs of homeless and at-risk clients, committed to providing better access to support services such as transportation and mental health care, as well as education, training, and employment services to promote long-term stability. Denver's plan includes developing 580 employment opportunities in

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	homeless population in Denver provided the information necessary to develop a unique plan that addresses the need of homeless people in the area. Denver's strategy consists of eight different goals. Within each goal, the plan outlines specific benchmarks serving as year-to-year guidelines and defining successful implementation.	the 10-year period for homeless and formerly homeless persons. 5 & 7. Focus on Public Safety, street outreach to homeless, and increase community awareness in calling for increased coordination with governmental and nongovernmental agencies dedicated to ending homelessness. 8. Collaborate with local housing developers, funding agencies, and officials to review existing housing codes and to identify changes to facilitate the construction of permanent affordable units. Denver plans for a reformation of zoning codes to allow large shelters to continually operate at overflow status. This increases the capacity up to 350 beds, expanding the amount of people who can be served without suspending the zoning ordinance for shelters. Further, Denver's plan calls for an expansion of the zoning code, to allow shelters in mixed-use districts to ensure adequate space for all persons in need during construction of permanent housing units. Source: *The Ten Year Plan to End Homelessness,* a report to the citizens of Denver by the Denver Commission to End Homelessness
Grand Rapids, Michigan[1]	Grand Rapids, Michigan packages their plan action steps into three principles: close the front door, open the back door, and build the infrastructure.	*Close the Front Door* – Grand Rapids will target prevention through a coordinated application form for benefits requested through various public assistance programs. A housing assistance revolving pool will allow the continuum to resolve minor issues such as late rent, mortgage, or utility payments before the eviction process begins. To help curb eviction before it starts, the plan calls for developing landlord–tenant education and information sessions. The Grand Rapids plan also intends to broaden the central intake system to increase the population served and enhance the services for prevention and placement in permanent housing. System coordination will be managed through a specialist directly responsible for discharge planning for prison/jail, foster care graduates, and those leaving mental/physical health institutions. *Open the Back Door* – Emergency shelter use will be dramatically decreased. In order to address emergencies, Grand Rapids intends on providing a brief, interim housing with a goal of rapid placement and long-term success. For example, the short-term crisis shelter option will be interim housing for 1 to 90 days, ending as soon as a permanent unit is found for the homeless person/persons. Wrap-around services will also be provided with the permanent housing as needed. Thorough screening for housing readiness will help to gauge how ready one is for housing and to enable the tailoring of services to the needs of the client. Whenever possible, clients will be given a choice of housing where affordable ownership and rental options will be provided with supportive services as needed. *Build the Infrastructure* – Building the infrastructure involves expediting access to mainstream resources, and funding a pool for those awaiting public benefits in Grand Rapids. HMIS will be used to inform community planning efforts around the provision of housing. In the next few years, Grand Rapids intends on gathering their baseline data regarding current affordable housing stock, the affordable housing needed, and the number of people who are at risk of homelessness in the region. Funding allocations will be informed by a broad cost/benefit analysis of the data collected and analyzed. Source: *Vision to End Homelessness,* Grand Rapids Area Housing Continuum of Care
Hartford, Connecticut[1]	The Hartford Continuum of Care estimates that 322 chronically homeless individuals (240 sheltered and 82 unsheltered) live in Hartford. *Hartford's Plan to End Chronic Homelessness by 2015* identifies "gridlock in treatment systems," prison releases, termination of	The plan focuses on permanent supportive and affordable housing, calling for 2,133 units to be built in the "Capitol Region" over the next 10 years. Half of the units will serve long-term individuals and families—half of the long-term housing units will be built in Hartford proper. Linking housing with services is critical for communities serving chronically homeless people. Hartford's plan calls for better discharge planning and the active prevention of "graduating" people into homelessness, whether from prison or foster care. Enhanced data collection through continued support for the development and implementation of HMIS is

Government Entity	Program Description	Best Practices
	benefits, and high housing costs factors that contribute to an increasing chronically homeless population. Hartford took a regional approach addressing homelessness by working with surrounding communities.	integral to Hartford's plan to end chronic homelessness in 10 years. Increased use of HMIS involves identifying both chronically homeless and those at risk of becoming chronically homeless. Increasing attention to data and HMIS will allow Hartford's Chamber of Commerce to understand the needs of the chronic homeless, target funds appropriately to address the needs of the chronic homeless, and track their progress in reducing chronic homeless. The HMIS will be reviewed on a quarterly basis to ensure high-quality data collection. As a benchmark for utilization, Hartford has declared that by September of 2006 all service providers, including emergency shelters, supportive housing, and transitional housing facilities, will have entered data on at least 80 percent of their beds. Source: *Hartford's Plan to End Chronic Homelessness by 2015,* The Commission to End Chronic Homelessness, Prepared for Mayor Eddie A. Perez, June 2005
Minnesota [4]	Minnesota's housing finance agency (HFA) has committed to increase the supply of supportive housing for people covered by the governor's plan to end chronic homelessness.	The plan anticipates $200 million for such housing, with $50 million already pledged by HFA for new construction, rehabilitation, or rent subsidies for chronically homeless people. Of the 1,937 additional units HFA funded by the close of 2005, 669 were committed to this group. Social and human service providers will deliver services to these new residents as their eligibility for services allows, and a new $10 million fund will assist with supportive services not otherwise funded. Efforts also are underway to engage more private sector involvement in supportive housing development for chronically homeless people.
New York, New York Hard to Place Task Force [2]	The Hard-to-Place Task Force serves as a model of city-state interagency collaboration to address long-term homelessness. In an effort to bring together many of the various entities involved in setting policy for working with long-term shelter stayers, Mayor Michael Bloomberg's administration in New York City established the Hard-to-Place Task Force in 2002. Members include representatives from city and state government agencies as well as a few nonprofit organizations. The task force meets regularly and has made significant progress toward improving services for those who are homeless for the long-term. The task force is co-chaired by staff from the New York City Department of Homeless Services (DHS) and the New York State Office of Mental Health (OMH). The task force met monthly initially and now meets quarterly. The task force focuses on reducing the number of individuals in the municipal shelter system. Meetings are a time for different organizations to update each other	Accomplishments • *Project MatchUp.* Under Project MatchUp, whenever a new supportive housing project opens its doors, the project is matched with a shelter that has long-term residents. A set-aside of units, typically 25%, is negotiated and all agencies involved assist the provider in placing the long-term shelter stayers in these permanent supportive housing units. o Two benefits of the program are that it is relatively easy to understand and tracking results is simplified. o The program encourages supportive housing providers to proactively serve the most challenging clients, and not just those clients that actively seek housing from them. o The program also benefits supportive housing providers by creating a more stable community faster, since many of their new residents know each other from their previous shelter. o Shelter providers are often pleasantly surprised that their long-term residents can be very successful in supportive housing. o Keys to success: • DHS has hired a couple of staff to oversee the entire process, including which shelter gets matched with each opening. • The supportive housing provider must have a weekly presence in their matched shelter 2-3 months in advance of opening to build familiarity and trust with long-term shelter stayers. • A key management staff person from the shelter must be involved in the process so that it is taken seriously. • *New dedicated staff.* New York City's Department of Homeless Services hired two new permanent program analysts to focus on individuals homeless for the long-term in early 2004. The new staff is analyzing the barriers to leaving shelters and working to improve the situations one location at a time. • *New awareness.* The NYS Office of Mental Health has recognized long-term shelter stayers as a critical issue, citing them in its *Statewide Comprehensive Plan for Mental Health Services.* • *Data collection and sharing.* DHS and its shelter vendors maintain a database of all individuals and families in the shelter system. This system has allowed DHS to collect an accurate account of the number of homeless people in the system at any given point, their length of homelessness, and their number of incidences of shelter usage. This ability to collect complete and accurate information has allowed DHS and others working with them to analyze the data and trends, including changes over time. Additionally, the

Government Entity	Program Description	Best Practices
	about news in their respective programs. The meetings also provide an ideal forum for problem-solving. Having people with a variety of levels of responsibility, from line staff to decision-makers, in the room at one time allows problems to be raised and solutions implemented swiftly.	Human Resources Administration's (HRA) Office of Mental Health Housing has begun to identify and coordinate with DHS around those shelter stayers who may be mentally ill. Now, HRA and DHS are cross-checking and sharing data. Not only does this save staff time and resources, it also highlights unidentified mentally ill shelters stayers who qualify for mental health housing. • *Assertive Community Treatment (ACT) Teams.* The city and state jointly contracted with two ACT teams to work with 136 long-term shelter stayers who may be eligible recipients of set-aside Section 8 vouchers. Originally, the New York City Housing Authority (NYCHA) had laid out a plan for "expedited Section 8 vouchers" that would have taken 10-12 months from application to receipt of a voucher. The Hard-to-Place Taskforce worked with NYCHA to reduce the wait down to 6 weeks. • *McKinney-Vento priority.* The Continuum of Care has prioritized long-term shelter stayers for both new awards and renewals. Existing supportive housing projects must fill every third vacancy with a long-term shelter stayer until the population occupies 25% of the units. Lessons Learned • The group must have key decision makers from each agency in the room. In addition, participation of policy makers and line staff is extremely valuable. • Participation must be comprehensive, that is, every system that touches clients' lives must be present. For example, if a client interacts with both a city and a state agency to receive services, both must be present at the table. • The collection of data is a critical, first step to identifying and tracking problems or trends. For example, shelter providers might have had "a sense" that some shelter stayers were there for long period of time, but until DHS could analyze the data and realize that 17% of the shelter stayers used 50% of the shelter bed-days, the anecdotal information from shelter providers was insufficient to ignite specific programs or policies. • Government entities and Continuums of Care should recognize their ability to address the needs of the chronically homeless through contracts and regulatory changes. By DHS implementing "Match-Up" and the Continuum of Care requiring that a percent of new and turned-over units go to long-term shelter-stayers, attention and outreach to this population has been achieved at a level that would not otherwise likely be possible.
New York, New York Pathways to Housing [2]	Pathways provides *housing first* for individuals who have psychiatric disabilities and substance use disorders who have been turned away from other agencies because they were not considered housing ready. Pathways does not require participation in psychiatric treatment or sobriety as a condition for housing. Pathways pursues its mission by providing these individuals with apartments of their own, and then offers extensive ongoing treatment and support services through interdisciplinary Assertive Community Treatment (ACT) Teams. The ACT Teams, comprised of social workers, service coordinators, nurse, psychiatrist, peer counselors, and an employment specialist, are located at four New York	The program is founded on the belief that housing is a basic right for all people and that people with psychiatric disabilities should be fully integrated into our communities. The program is intensively client-driven, that is participants are respected as individuals who can make an informed choice about what they want, the sequence they want it in, and for how long they want the service. Typically, clients say that housing is what they want *first.* After clients are housed, the ACT team staff work in partnership with clients to develop service plans and learn the skills they need to maintain and apartment and develop a sense of community. Assertive Community Treatment (ACT) Teams engage and provide treatment and support services. These interdisciplinary teams include a social worker, a nurse, a peer counselor, a vocational rehabilitation specialist, and a psychiatrist. One team member is on-call 24 hours a day, seven days a week. The Pathways ACT teams serve as the single point of contact for most clients and provide most services directly. The teams work from agency field offices around the City. In each site, Pathways has developed extensive linkages to local services, including primary care and housing referrals and placements. The staff team members to client ratio is approximately 1:10. Through Pathways vocational program clients can be employed at minimum wage or higher within the agency as clerical workers, messengers, maintenance workers, painters, movers, and "buddies" who make apartment visits to new tenants and help them adjust to the program and their new homes. Vocational planning is a part of the service plan developed with each client. Recently, Pathways to Housing opened a

Government Entity	Program Description	Best Practices
	City sites: East Harlem, West Harlem, Brooklyn, and South Jamaica, Queens. ACT Teams conduct outreach to homeless people on the streets, in parks, subway stations, abandoned buildings, and other public places I and moves them directly into permanent housing. Pathways' pioneering approach has produced an impressive housing retention rate of 85%.	thrift shop in Queens as a social purpose business affording clients jobs while producing revenue for the agency. In a recent SAMHSA study, 225 individuals with psychiatric disabilities who were also homeless were randomly assigned to either the Pathways program or to traditional New York City services. At the end of 12 months, 80% of the clients assigned to Pathways to Housing were stably housed compared to 23% for the comparison group. Once housed, the self-reported quality of life improved at comparable levels in both groups, and noteworthy is that there were no differences in the levels of substance abuse or psychiatric symptoms between the two samples. The study concludes that housing first without pretreatment requirements is very effective in ending homelessness and does not does not adversely affect substance abuse or psychiatric symptoms.
New York, New York Safe Havens [2]	Created under the McKinney-Vento Act, Safe Havens offer a "housing first" approach to help street homeless people with mental illness move into interim or permanent housing units. Thresholds in Chicago and Goddard Riverside Community Center's Project Reachout (PRO) in New York are two examples of Safe Haven programs aimed at ending chronic homelessness.	*Goddard Riverside* provides on-site services three weekday evenings and on the weekends to support the success of participants in transitional housing. Staff provides patient, individualized attention to each participant, allowing the program to serve people who are not yet stable and present a wide range of needs. All participants share in community chores such as cooking, setting the tables and washing up after meals. Staff assesses people's independent living skills and provides training tailored to each person's needs. An on-site MICA specialist offers individual and group substance abuse counseling each week. The Safe Haven program creates a relaxed environment that allows participants to feel at home. Living amongst permanently housed residents sparks participants' interest in the housing process and obtaining permanent rooms of their own. Goddard Riverside's Safe Haven programming includes a Community Meeting, a Meditation Group, a MICA Group to support sobriety, Community Dinners, and weekly trips to special events throughout the city such as musical performances, beach excursions, and sports events. Birthdays are always celebrated, and when participants achieve permanent housing they are congratulated by peers and staff at special Sunday brunches.
Oakland, California Fred Finch Youth Center [2]	Programs for Transition-Aged Youth provide comprehensive and individualized services to youth transitioning out of foster, residential, or family care and into adulthood, as well as supported transitional and permanent housing for youth who have been homeless or who are exiting the fostercare system and have mental-health diagnoses. We also offer vocational services through a multi-tiered approach of career exploration, job-skills development, and supervised work experience.	*Coolidge Court* provides eighteen units of assisted independent living for qualified tenants. Tenants are typically between 18 and 21 at the initiation of tenancy, have been recently in the foster care system and typically have an axis one mental health diagnosis that impedes their smooth transition into adult life. The apartments are designed to provide both opportunities for community as well as full independence to each tenant. Concurrent services include case management and brokerage, mental health services through our transitions program (see below) when indicated, and on-going education and practice in independence. The *Supportive Housing for Transition Age Youth (STAY) Partnership* is a formal partnership between FFYC and Tri-City Homeless Coalition, which administers the housing component of this new Alameda County program (awarded December 2006) under the Mental Health Services Act. The STAY Partnership provides both safe housing and wellness and strength-based services for 30 concurrently engaged young adults on their journey of self-discovery, healing, and emerging independence. The program realizes a vision of recovery and discovery, asserting each youth's unlimited potential, promoting resiliency by building up hope, responsibility, self-determination, personal empowerment, respect, and social connections. The STAY Partnership offers multiple pathways appropriate to TAY's needs, preferences, experiences, and especially their cultural backgrounds, that they may shape their own futures and achieve permanent connections within communities of their choice. We provide and facilitate a continuum of housing and services, including shelter care, transitional housing, permanent housing, satellite housing support, access to substance-abuse treatment in-patient resources, and family support, with an emphasis on housing options that are permanent and lasting and end the continuous cycle of abandonment these youth have faced. Other approaches to develop resilient, socially minded self-advocates include vocational, educational, health, and psychiatric services, financial mentoring, advocacy, transportation, and rehabilitative visits from staff.

Government Entity	Program Description	Best Practices
		Turning Point is located at two sites in Berkeley. Home to 18 transition age youth, this program provides supported housing with comprehensive services, including vocational and educational advising and support, health connections and education, mental health services, substance abuse counseling emphasizing harm reduction toward abstinence, housing advocacy, and mentoring, including ILSP skills development, tenant and roommate skills, and locating housing. Youth come to us after a period of homelessness; most have histories of involvement with juvenile justice and/or child welfare services. The Transition Age Youth (TAY) Partnership is a collaborative initiative that joins the resources of FFYC with those of two other agencies, the Greater Richmond Interfaith Program (GRIP) and The Latina Center, as well as Contra Costa County Mental Health Services, in a new program (awarded December 2006) under the Mental Health Services Act. With FFYC acting as the lead agency, the TAY Partnership serves 135 concurrently engaged transition-age youth in West Contra Costa County, focusing on unserved or underserved TAY, especially homeless youth. The TAY Partnership accompanies and assists TAY through their recovery journeys, employing a "whatever-it-takes" commitment to positive outcomes. We provide a continuum of housing (administered by the County) and services, including shelter care, transitional housing, permanent housing, satellite housing support, access to substance-abuse treatment in-patient resources, and family support. Other approaches to develop resilient, socially minded self-advocates include vocational, educational, health, and psychiatric services, financial mentoring, advocacy, transportation, and rehabilitative visits from staff. The *Vocational Department* at Fred Finch Youth Center is funded through a California Department of Education Work Ability (WAI) Grant. This grant provides career assessment, exploration, training, work placement and support for youth ages 14-22 with active IEPs (Individualized Education Programs). Through Vocational Programming at Fred Finch, adolescents and young adults with special needs gain critical employment skills, training, and experience, both on and off-campus. The program is designed to help youth navigate the complex transition from school to employment and a quality adult life. With the help of the therapeutic milieu and agency-provided educational programming, and collaborations with community based organizations, the Vocational Department provides educational supports, career exploration, compensation for work, and independent living skills development for adolescents.
Portland and Multnomah County[1]	The Portland and Multnomah County plan has taken a direct approach to solving the issue of homelessness. Three simple principles guide their strategy: focus on the most chronically homeless populations first, prevent new homelessness by streamlining access to existing services, and concentrate resources on programs that have been effective. The plan recognizes that eliminating homelessness in 10 years will require the participation of all homeless service providers.	The Ten Year Plan offers steps by which to accomplish this goal by the year 2015: 1. Move people into Housing First. 2. Stop discharging people into homelessness. 3. Improve outreach to homeless people. 4. Emphasize permanent solutions. 5. Increase supply of permanent supportive housing. 6. Create innovative partnerships to end homelessness. 7. Make the rent assistance system more effective. 8. Increase economic opportunity for homeless people. 9. Implement new data collection technology throughout the homeless system. These nine steps have contributed to significant progress in Portland and Multnomah County's mission to end homelessness in 10 years. In the last year, new resources have been secured through two large federal grants and a Robert Wood Johnson Foundation grant to implement systems change to help end chronic homelessness through permanent supportive housing. The Housing First approach has helped move 436 homeless into permanent housing, and 64 chronically homeless into permanent supportive housing in the last year. As of September 2004, there were 350 new units of permanent supportive housing with a goal of 400 by 2007 and 1,600 by 2015. The Transitions to Housing program has provided over 1,300 households with short term rental subsidies. Twelve-month estimates show that 71 percent of households retained permanent housing free of rent assistance, and the latest figures show that

Government Entity	Program Description	Best Practices
		households, on average, have increased their monthly income by almost 35 percent. Finally, Portland has implemented a HMIS through successfully securing a HUD grant. This system will serve more than 20 nonprofit agencies with a better tool for the data collection and analysis of Portland's homeless population, and better data create better solutions. Source: *Home Again: A 10-Year Plan to End Homelessness in Portland and Multnomah County*
San Francisco, CA Direct Access to Housing [5]	DAH is an initiative of the Housing and Urban Health (HUH) unit within the Community Programs Division of the San Francisco Department of Public Health (SFDPH). HUH funds and controls access to housing units that are master leased from private owners and infused with supportive services and professional property management. Established in 1998, the San Francisco Department of Public Health's (SFDPH) Direct Access to Housing (DAH) program provides permanent housing with on-site supportive services for approximately 600 formerly homeless adults, most of whom have concurrent mental health, substance use, and chronic medical conditions. SFDPH, with a budget of over $ 1 Billion annually, operates a large public hospital, the largest publicly funded skilled nursing facility in the country (1,200 beds), 26 primary care and mental health clinics, and contracts for a broad array of services through community-based providers. Finding appropriate housing for individuals who have few family or community connections is a major challenge for staff of these public or community-based organizations. Without access to a stable residential environment, the trajectory for chronically homeless individuals is invariably up the "acuity ladder" causing further damage and isolation to the individual and driving health care costs through the roof. The DAH program was developed in an attempt to reverse this trajectory through the provision of supportive housing directly targeted toward "high-utilizers" of public health system.	DAH is a "low threshold" program that accepts single adults into permanent housing directly from the streets, shelter, acute hospital or long-term care facilities. Residents are accepted into the program with active substance abuse disorders, serious mental health conditions, and/or complex medical problems. All ten sites have between three and five on-site case managers as well as a site director. Case managers assist residents to access and maintain: benefits, life skills and family counseling, medical and behavioral health (mental illness and substance abuse) treatment, food and clothing, and property management to assist in preventing eviction. All ten sites also have access to a roving behavioral health (BH) team for scheduled one-on-one counseling and groups and can be available five days a week for rapid intervention and placement of residents in off-site mental health and/or substance use residential treatment. The primary goal of the BH team is to prevent eviction resulting from exacerbation of mental health and substance use disorders. While in residential treatment, a resident's permanent room is held for them for the duration of the treatment. BH counselors follow patients while in residential treatment and assist in reintegrating them back into the community after treatment. All sites have access to some medical care. Most residents have primary care providers at one of the public health clinics. At the RCF, there is around the clock nursing services. At all sites, staff meet monthly with the medical director for the DAH program to assist with medical treatment plans and to strategize on how to access appropriate medical and psychiatric care in the community. All residents in the DAH facilities have tenant rights and all services offered to residents are voluntary. On-site support service staff actively engages residents and attempt to assist individuals in making choices that reduce their physical, psychiatric or social harm. Over time, as residents develop trust in the on-site staff, the resident is able to work with the staff to develop and adhere to an individualized treatment plan. For residents that are unable or unwilling to accept offered services and/or to reduce harmful behavior, staff continues to regularly engage residents in dialogue and continue to offer services. A considerable amount of staff meeting time and supervision is spent supporting staff to maintain empathy and engagement with residents despite some resident's poor choices and outcomes. The main goal of the DAH program is to provide housing to a group of people that have rarely, if ever, maintained stable housing as adults. Since opening the first DAH site in 1998, almost two-thirds of the residents have remained housed in the DAH program. Of the remaining one-third of the residents who moved out of the program, half moved to other permanent housing. Only 4% of residents were evicted from the housing facilities. Evictions usually resulted from repeated non-payment of rent (despite money management), violence or threats to staff or residents or destruction of property. Not surprisingly due to the severity of medical illnesses among the population housed in DAH, 4% of DAH residents have died. Overall, DAH residents used a considerable amount of health care services prior to entering the DAH facility. Each DAH resident averaged 12 visits to outpatient medical services in the year prior to placement in the facility. After placement, there was little change in outpatient visits in part because on-site case managers encourage residents to maintain primary care appointments. On the other hand, emergency department use was reduced significantly after housing with a 58% reduction in emergency department utilization after entering the program. Similarly, in the first two years after entering the program, there was a 57% reduction in inpatient episodes after entering the program compared to the two years prior to housing placement. About one-sixth of residents had exacerbations of their mental illness leading to psychiatric

Government Entity	Program Description	Best Practices
		hospitalization both before and after placement in the program. However, the number of days per hospitalization decreased significantly after placement. This is not surprising as discharge from psychiatric hospitalization is often delayed due to lack of available appropriate community based housing. The DAH program routinely holds a resident's permanent housing unit during a period of acute exacerbation of their mental illness.
San Francisco, California Local financing of supportive housing [2]	The City and County of San Francisco has been focusing on supportive housing for ending long-term homelessness since the mid-1990's. Much of the city's investment in supportive housing has come from dedicated financing sources, included a general obligation bond issued by the city and a dedicated portion of the city's hotel tax. Establishing public financing of supportive housing in San Francisco was a gradual process of learning and change. First, in the mid-1990's, nonprofit developers who had been developing affordable housing for years told the Mayor's Office of Housing (MOH, the city's main affordable housing coordinating and funding office) that they needed funds to provide supportive services in housing they were already operating. The developers found that their property managers were having to do double duty, working both on property management and supportive services.	San Francisco's experience points to the need to recognize that the resources required to do supportive housing well are controlled by multiple agencies within city government and beyond. Supportive housing can often be constructed with the capital funding mentioned above, but services and operating still must be accounted for. In San Francisco, services funding comes through the city's Department of Human Services (DHS) (for case management services) and the Department of Public Health (DPH) (for substance use and mental health services). For a more detailed look at the complex web of financing supportive housing, as well as information on all of the main federal funding sources, please visit CSH's Financing Supportive Housing Guide at http://www.csh.org/financing. At CSH's suggestion, MOH works at the staff level with DHS and DPH on planning supportive housing. MOH consults staff from its sister agencies about what requirements should be put into funding availability notices and applications. This involvement of DPH and DHS from the beginning of the process helps the cause of supportive housing because these agencies now know what new supportive housing is coming to the city. Additionally, these agencies provide MOH valuable assistance in evaluating the services component of proposed supportive housing programs. Staff of DHS and DPH are on the loan approval committee to determine which supportive housing construction projects are funded by the city. Similar coordination happens with the Section 8 staff from the San Francisco Housing Authority. Of all of the sources detailed above, the city has found the hotel tax and bond funds to be the most flexible for use on supportive housing projects. HOME and CDBG funds are most useful for rehabilitation projects (as opposed to new construction) because of their implementation regulations and interaction with tax credit law. MOH staff notes that for other municipalities, the sources of dedicated funds for supportive housing will depend on local politics. For example, San Francisco has considered a real estate transfer tax to fund supportive and affordable housing development, but this effort has been consistently opposed by realtors. Many in San Francisco see the need for a similar dedicated funding source which does not have to go before the voters for approval every few years. MOH also urges other municipalities to recognize that "it takes all kinds of supportive housing to serve the community. Cities must be open to all members of the community who need supportive housing. No one model is going to work. San Francisco has housing for people who are struggling with substance use who can stay in that place as long as they don't harm themselves or others. On the other hand, the city also has housing that is clean and sober and there are many people who want that" (Joel Lipski, MOH Housing Development Director). Information about San Francisco Mayor's Office of Housing is located on the web at http://www.sfgov.org/site/moh_index.asp
San Jose, California [3]	Recognizing both the social and the economic imperatives to address the shortage of affordable housing in San Jose, the mayor, city council, and municipal staff collaborated on the city's comprehensive Five-Year Housing Investment Plan. They assessed the city's policies, resources, and programs	The mayor established a housing production team, made up of public and private-sector housing professionals and advocates, to propose ways to enhance current housing policies and identify innovative financing resources that would help to expand and develop the city's affordable housing stock. The task force identified 72 reforms, including streamlining the city's planning and building approval process and revising the city's zoning procedures to give developers added flexibility when designing affordable housing projects. The city also initiated a housing opportunity study to investigate the shortage of large development sites for housing, with a particular focus on sites with existing city services, infill areas, underused or vacant parcels of land suitable for higher development densities, and locations close to transportation hubs. Lastly,

Government Entity	Program Description	Best Practices
	to find ways to expand the supply of affordable housing and increase production by 50 percent. As a result, the city carried out an aggressive, progressive strategy that implemented several initiatives.	a housing action team was created to enhance communication among the various city departments that regulate the approval process for affordable housing developments. Better interdepartmental communication led to early problem-solving, a more efficient review, and continuous feedback on requirements for planned developments. These process improvements, in turn, increased developer interest in the city's affordable housing program. In a span of five years, the City of San Jose created more than 6,000 new affordable housing units, providing long-term affordability for low- and moderate-income families in one of the highest priced cities in the country. And by mid-2005, the city had completed an additional 1,500 units. By implementing collaborative policy initiatives, engaging effective partnerships, employing progressive planning techniques, and assembling creative financing portfolios, the city not only fulfilled its five-year target but is on track to fulfill its goal of having more than 10,000 units completed or under construction by December 2006.
Washington [3]	A Regional Coalition for Housing (ARCH) in east King County, Washington, preserves and expands the housing supply for low- and moderate-income households in the Seattle area by coordinating a variety of city housing initiatives. By creatively leveraging scarce resources, ARCH is bringing quality, affordable housing to communities that desperately need it. Administered by the State of Washington's Department of Social and Health Services (DSHS) with funding and technical assistance from the Robert Wood Johnson Foundation, the Washington Coming Home Program was created and designed to develop affordable models of assisted living for low income seniors across the state, with particular focus on smaller and rural communities.	*Washington Coming Home Program*: Over the past two decades, a number of alternative models to the traditional nursing home have been developed to provide senior and elderly consumers with options in eldercare that meet both their housing and health care needs. One such model is the assisted living facility — an establishment that provides private rental housing combined with round-the-clock supportive services (e.g., help with personal care, housekeeping, and medication management) and access to health care. While Washington, with its established and well-financed home- and community-based services program, was among the first states to pioneer assisted living as a residential alternative to institutional care, for many years the state lacked affordable assisted-living resources for low-income seniors. In addition, over the past decade, Washington has experienced a significant increase in the number of low-income, frail elderly individuals in rural areas of the state. Many of these individuals were forced to choose between adequate health care and decent housing with incomes barely enough to support either. Creating affordable assisted living (AAL), including projects that accept Medicaid, is no easy task. Housing developers and service providers must first build successful partnerships that enable them to craft integrated AAL implementation strategies that incorporate complex blends of housing and Medicaid programs. DSHS succeeded in bringing together nonprofit sponsors, private developers, and federal and state housing financing agencies as partners, a collaboration that resulted in an innovative, replicable, and first-rate demonstration project. As conduit, the Washington Coming Home Program was able to bridge the divide between the service providers and housing developers. Their unique partnership enabled each to learn about and respect their individual roles, overcome any apprehension about forging a relationship, and successfully undertake the challenge of a complex new model.

II. Local Programs in Los Angeles

Program Description	Best Practices
Childrens Hospital Los Angeles	In 1982, the Division of Adolescent Medicine at Childrens Hospital Los Angeles began providing community-focused medical care, mental health, and outreach for at-risk adolescent populations. Over time, the Division developed specialized programs in order to improve access to medical care and promote health and well being among vulnerable populations. One of these programs was the High Risk Youth Program, serving runaway and homeless youth. During that period, agencies serving runaway and homeless youth (RHY) in Hollywood developed collaborative structures to facilitate interagency planning and avoid duplication of services.
Hollywood Homeless Youth Partnership (HHYP)	In 1993, the collaboration evolved into the Hollywood Homeless Youth Partnership (HHYP), a network of eleven agencies working together to ensure that services are responsive to the changing needs of homeless youth and that the continuum of care provided supports the successful transition of youth to a more stable environment. Through this collaboration, the High Risk Youth Program has been able to expand the manner in which it impacts the care for RHY: High Risk Youth Clinic, Mobile Health Team, Homeless Youth and Exploitation Program, Community Collaboration to Prevent Youth Abuse and Promote Youth Development, Trauma Initiative, and Comprehensive Multi-Agency Needs Assessment. The High Risk Youth Program is part of the Hollywood Homeless Youth Partnership (HHYP), which works collaboratively to plan and implement a continuum of care and services for homeless youth. Services include: street outreach, case management, counseling and education, drop-in centers, food and clothing services, independent living and life skills, health care, emergency housing, and transitional living/housing. Two shelters for minors included in the partnership are Angel's Flight (Catholic Charities) and the Los Angeles Youth Network. The agencies of this partnership strive to work together to determine the best use and allocation of funding to fill gaps and better meet the needs of homeless youth in Hollywood.
Coordinating Council for Runaway and Homeless Youth (CCRHY)	The purpose of the Coordinating Council for Runaway and Homeless Youth is to establish a partnership of individuals, projects and organizations that will empower each to be more effective in making a positive difference in the lives of young people who are runaways, homeless, or at-risk of being homeless. The Coordinating Council for Runaway and Homeless Youth (CCRHY) was established in 1985, through a grant from the California Office of Criminal Justice Planning to Childrens Hospital Los Angeles, under the Homeless Youth Act of 1985. The Council was designed to bring public and private agencies together to consolidate resources and establish a system of care and support for homeless young people. Today, over 40 public and private agency partners throughout Los Angeles County are active in the Council, and meet quarterly to coordinate resources, identify service gaps, provide training, and direct public policy and education efforts. Most runaway and homeless youth are victims of abuse, neglect, severe family conflict, or destructive home environments. Many become homeless after unsuccessful foster care placements. On the streets these young people face a number of risks – HIV infection, health problems, substance use and violence – and struggle to survive without adult support or supervision, distrustful of traditional care providers. The CCRHY seeks to develop a comprehensive response to meet the needs of these young people, building a system of community-based services, addressing system barriers, reducing risks and preventing long-term homelessness. CCRHY activites: • Conducts quarterly meetings to facilitate networking with public and private agencies. • Develops and strengthens agency capacity through training and technical assistance. • Gathers, organizes and disseminates pertinent data and information. • Promotes service coordination and linkage through fax alerts and mailings. • Provides leadership in public policy and program development. • Facilitates linkages to state, regional and national coalitions.
Source: information provided by Childrens Hospital Los Angeles	

Program Description	Best Practices
Community Model/LAMP (Los Angeles Men's Place)[5] The Community Model is a comprehensive method of service provision that has helped thousands of homeless people with mental illness achieve residential stability and an improved quality of life. Employing harm reduction service strategies in a safe, flexible and non-hierarchical environment, the Community Model allows people to tailor their own paths to recovery and wellbeing. The Community Model has proven particularly effective at serving dually-diagnosed individuals and other members of the vulnerable and difficult-to-engage chronically homeless population.	A prototype for the federal "Safe Havens" program, the Community Model's success also helped shape the federal government's recent "Collaborative Grant to Help End Chronic Homelessness" initiative. Over the years, the Community Model has been adapted and replicated by other nonprofit providers, most recently by the OPCC (formerly Ocean Park Community Center) network of shelters and services in nearby Santa Monica. Lamp Community's use of the Community Model has helped end the homelessness of thousands of individuals during the past two decades. Two years after placement, approximately 70% of Lamp Community's members remain stably housed in independent housing, transitional housing or the respite shelter, an extremely high rate of success for this challenging population. This is all the more impressive because most people served by Lamp Community have repeatedly failed to complete other programs. While almost all of the participants in the Community Model experience an improvement in their health and wellbeing and a decrease in psychiatric instability and substance use, these goals are secondary to the primary goal of achieving residential stability. Once they are stabilized in housing, these other positive outcomes naturally follow. As a result, participants increase their independence, socialization and even employability, while reducing their dependence on expensive systems of emergency care, including psychiatric and medical hospitals, the criminal justice system and emergency shelters. Lamp Community's development and use of the Community Model has been repeatedly recognized as an innovative program that reaches some of the most challenging to engage individuals within the homeless population. It received HUD's Community Service Excellence Award, was cited as a model by the California State Governor and is one of a handful of agencies being studied by a nationwide HUD best practices research project.
My Friend's Place is the most frequently visited drop-in Resource Center for homeless youth in Southern California serving 1,000 youth ages 12 and over and their children, each year. Many of the referrals to My Friend's Place are through youth who have received help over the years. Source: www.myfriendsplace.org	In collaboration with the leading social service providers and educational institutions in the region and over 200 volunteers, we offer a free comprehensive continuum of care that combines emergency necessities with therapeutic, health and education services through three program areas: Safe Haven Program, Transformative Education Program, and Health & Well Being Program. My Friend's Place is the *only* Resource Center for homeless youth in Los Angeles providing drop-in services seven days a week. The organization is not government or religiously affiliated and is 100% privately funded. They are the most visited Resource Center for homeless youth in Southern California. • Low barrier service structure: We minimize the psychological, physical, and social barriers that typically deter youth from seeking and accepting assistance from a social service agency. • Harm reduction approach: We provide education and support so youth can reduce harm caused by high risk behaviors associated with street survival. *My Friend's Place Guiding Principles:* *Human Worth* - We believe each homeless youth has inherent value, is competent and resourceful, and possesses something unique to offer society. Each youth deserves respect, understanding and the opportunity to reach their full potential. *Individualized Response* - We treat each youth's needs, potential, thoughts and feelings with specialized attention unique to the individual. *Trust* - We believe trust is the cornerstone to rebuilding hope and pride in the youth we serve. Under no circumstances will we jeopardize trust to accomplish our goals. Trust must be consistently, continually reinforced among and between youth, staff, volunteers and community members. *Low-Barrier* - We minimize the psychological, physical, and social barriers that typically deter youth from seeking and accepting assistance from a social service agency. *Judgment-Free* - We foster an environment that is free of shame and protects the pride and dignity of each individual, including youth, staff, volunteers or community members. We deny service to no one within our age range regardless of gender, race, class, economic status, ethnic background, sexual orientation, physical and mental health, cultural and religious backgrounds, legal status, or political platform. *Harm-Reduction* - We provide education and support so youth can reduce harm caused by high risk behaviors associated

Program Description	Best Practices
	with street survival. We believe that alleviating - not only eliminating - the severity of dangerous behaviors is a legitimate and valuable step toward recovery that should be encouraged and celebrated. *Strength-Based* - While preserving their dignity, we empower youth to uncover their strengths and use them as tools to achieve greater goals. We accept the responsibility of being a positive adult role model in each youth's life.
Santa Monica (City of) demonstrates its commitment to a strong continuum of care for homeless persons by expending $1.7 million of local dollars on twenty-two interconnected homeless service programs. The continuum of care begins with "front-end" programs (street outreach, emergency food and clothing, showers and lockers), continues with a variety of housing programs (emergency and transitional shelters, including special programs for the mentally ill, single women with disabilities, emancipated youth, and families), provides program participants with critical supportive services (case management, health care, mental health support when warranted, detox and sobriety programs, job readiness and placement programs), and finally assists successful participants with aftercare support (job retention programs, support groups, client networking, mentoring and volunteer opportunities, and social events). Source: U.S. Conference of Mayors. Best Practices: http://www.usmayors.org/uscm/best_practices	Although grassroots agencies have provided services to homeless people in Santa Monica for over twenty-five years, the current continuum of care was formalized with a HUD Supportive Housing Program grant beginning November 1, 1997, which linked the primary agencies providing services to the homeless through a computerized case management system. Through this system several benefits were identified: (1) services could be easily coordinated without duplication, (2) clients could be tracked as they moved through the continuum of care to help providers better understand their needs, (3) clients were able to have their records electronically transferred to referral programs rather than go through the process of re-registering each time they needed a supportive service, and (4) measurable outcomes were more clearly identifiable, with a snapshot of how many agencies and services were required to attain stabilization. Several of the above issues were raised in response to an initiative by the Santa Monica City Council to provide effective and measurable stabilization services to the homeless without unnecessary duplication. Measurement of Effectiveness Since the City's homeless service providers are networked on a computerized case management system, the City is able to run periodic and annual reports to determine the number of homeless clients served; a demographic profile of the local homeless population seeking services; the level and type of services delivered; the number who have been placed in emergency, transitional and permanent housing; and the number who have obtained job training, temporary or permanent employment. Financing of Program The City of Santa Monica provides approximately $1.7 from its General Fund and Prop A funding (a transportation initiative which provides bus tokens and passes) funding. The City also acts as a pass-through for approximately $500,000 per year in HUD Supportive Housing Program funding to provide additional supportive services (case management, job training, etc.) as well as the computerized case management system which tracks clients through the continuum of care. Linkage to City Government The City of Santa Monica is not a direct service provider but, rather, a funder to a variety of different private non-profit agencies which service the homeless. These agencies are Chrysalis (job training and placement), CLARE (detox and sobriety programs), Didi Hirsch Community Mental Health Center (mental health programs), New Directions (detox and job training for veterans), Ocean Park Community Center (outreach, case management, two day centers and two transitional living programs); Salvation Army (emergency and transitional shelters; showers, lockers, washers); St. Joseph Center (outreach, case management, showers, lockers, washers); Step Up on Second (case management, job training, support groups and independent living for the mentally ill); Upward Bound (transitional living for homeless families); Westside Food Bank (provides bulk food for homeless and low-income families); and the YWCA (transitional living for young women graduating from the foster care system). Major Lessons Learned A coordinated network of specialized services appears to work more effectively than having one or two agencies which attempt to be everything for everyone. The computerized system has allowed the City to accurately assess the number of unduplicated clients who participate in the continuum of care, as well as identify the vast number of support services required before a homeless person stabilizes. The City would recommend that other cities considering a computerized case management system carefully evaluate the software packages which currently exist and find the one most compatible to their individual needs.

Program Description	Best Practices
Skid Row Housing Trust was created in 1989 by a group of business leaders and community activists concerned with an increase in the demolition of single room occupancy (SRO) hotels and what would have become the subsequent purchase of the land parcels by commercial developers. Recognizing the need to salvage the hotels so that low income and formerly homeless tenants would not be forced to return to sleeping on the City's sidewalks, the Trust quickly moved to mobilize capital to preserve the hotels as affordable housing sites. Source: http://www.skidrow.org/index.html	Through a combination of private equity via low income tax credits, public financing, and grant dollars, the agency was able to secure buildings under immediate threat of demolition and restore them to units of decent, safe, and affordable housing. From the opening of the first property, in 1990, to the present, the Trust has developed or restored a total of 19 hotel properties comprising nearly 1200 units of affordable housing. Trust hotels have been recognized for their design, which incorporates both private and common living space in buildings designed to blend with the neighborhood's architecture. The 19 hotels are located within the 2.5 mile radius of the Skid Row neighborhood and very near public transportation. The Trust's residential units are supported by a community support center, the Service Spot, and a computer lab and classroom. These facilities serve to provide residents training in computers, job search assistance, workshops on topics related to societal reintegration and healthcare, and a monthly schedule of community and recreation activities. In addition, case management staffs, resident service coordinators, and a property manager are located on site. The Trust's Affordable Housing Program has proceeded at an aggressive pace, with at least 1-2 hotels per year put into operation. The Supportive Housing Program was implemented in 1993 to enable men and women to overcome the barriers that often prevent them from achieving housing stability. Resident services coordinators provide case management services, make mental health and primary healthcare referrals, organize social reintegration activities, peer support groups, health education and other social service supports geared toward helping tenants regain their lives. Today the Trust collaborates with over 20 public and private agencies to deliver a full spectrum of social services and healthcare referrals to the neediest and most underserved of the Skid Row community.

[1] Text directly from: *Research Report on Homelessness in America: A New Vision: What is in Community Plans to End Homelessness?* November 2006. National Alliance to End Homelessness. The report highlights best practices from a review of 90 complete plans. The report measured the strength of the plans by calculating a score for each strategy outlined based on the likelihood of it being implemented. This was based upon the identified: performance measures, timeline, funding sources, and bodies identified responsible.

[2] Text directly from: CSH website www.csh.org

[3] Text directly from: Karnas F. *Innovation Awardee Models in a New State Approach to Ending Homelessness.* Housing Facts and Findings. Fannie Mae Foundation. Vol 8, No 3, 2006.

[4] Text directly from: *Issue Brief: State Strategies to Address Chronic Homelessness.* NGA Center for Best Practices. April 27, 2007.

[5] Text directly from: Ending Chronic Homelessness Among People with Mental Illness: The Community Model. Shelter Partnership website: http://www.communitymodella.org/replication_manual.html